BOSTON COSMETIC SPECIALISTS
www.BostonCosmeticSpecialists.com
info@BostonCosmeticSpecialists.com

CLIENT QUESTIONNAIRE & MEDICAL HISTORY FORM

Contact & Background Information: **Today's Date:** _____

First Name: _____ Last Name: _____ Birthdate: _____

Home Address: _____ City: _____ State: _____ Zip: _____

Home Phone #: _____ Mobile Phone #: _____ Work Phone #: _____

E-mail Address: _____ Occupation: _____

Best number for confirmation calls? _____ Best way to contact you? At what times? _____

Are you single, married, divorced or widowed? _____ How did you learn about us? _____

Emergency Contact Information:

Emergency Contact Name: _____ Emergency Contact Phone #: _____

What is their relationship to you? _____ Can they pick up prescriptions for you? ☐Yes ☐No

Cosmetic Procedure Goals:

Indicate the areas you are considering for a procedure:

Face: ☐Nose ☐Cheeks ☐Chin ☐Lips ☐Eyelids ☐Neck ☐Ears ☐Skin ☐Acne

Body: ☐Abdomen ☐Flanks ☐Hips ☐Upper/Lower Back ☐Inner/Outer Thighs ☐Knees ☐Calves ☐Arms ☐Bra Bulge ☐Breasts

Other: ☐Male Chest (Gynecomastia) ☐Laser Axillary Sweat Termination (Hyperhidrosis) ☐Botox, Sculptra, or Dermal Fillers ☐ LHR

What is the primary reason for this consultation? _____

_____

What specific features of yourself do you dislike? Why? _____

_____

How long have you been considering a cosmetic procedure? Is this motivated by an event? _____

Is the cosmetic procedure your idea, or is someone else urging you to have it? _____

Do you understand that the object of any cosmetic procedure is improvement in appearance, not perfection? ☐Yes ☐No

Do you realize that every operation is followed by a period of healing before tissues return to normal and the final result is apparent? ☐Yes ☐No

Why did you select us for a consultation visit? _____

Cosmetic Procedure History:

Have you consulted any other physician about a cosmetic procedure? ☐Yes ☐No If yes, when? _____

Please tell us about any previous cosmetic procedures or cosmetic surgeries you've had: _____

_____

_____

Were you satisfied with the results? ☐Yes ☐No Were you satisfied with the physician(s)? ☐Yes ☐No

If not, why were you unsatisfied? _____

General Medical History & Evaluation:

Do you... Drink more than six (6) cups of coffee or tea daily? ☐Yes ☐No

Drink alcoholic beverages? ☐Yes ☐No If yes, how many per week? _____

Smoke? ☐Yes ☐No If yes, how much? _____

Use marijuana? ☐Yes ☐No If yes, how much? _____

Use recreational drugs such as cocaine, speed, LSD or heroin? ☐Yes ☐No If yes, which drug(s)? _____

Have any hobbies? ☐Yes ☐No

Spend much time socializing with friends and family? ☐Yes ☐No

Tend to wrap yourself up in your work or school, to almost total exclusion of other aspects of life? ☐Yes ☐No

Find that you are unhappy most of the time? ☐Yes ☐No

Feel lonely a great deal of the time? ☐Yes ☐No

List your current height: _____ Weight: _____ Gender: ☐Male ☐Female Age: _

Has your weight changed by more than five (5) lbs. in the last year? ☐Yes ☐No

If yes, how much weight have you lost or gained in the last twelve (12) months? _____

Have you taken Aleve®, Aspirin, Motrin® (or other medications containing Ibuprofen), in the last two (2) weeks? ☐Yes ☐No

How often do you exercise per week? _____ What kind of exercise do you practice? _____

When was your last physical exam? _____ At the physical, was everything OK? ☐Yes ☐No

Family Physician's Name: _____ Physician's Phone #: _____

List any previous surgeries or procedures not covered earlier: _____

_____

_____

If you have had surgery before, did you have any unusual bleeding or poor scarring following surgery? ☐Yes ☐No

Did you have a normal recovery following previous surgery? ☐Yes ☐No If not, explain: _____

Have you ever had a hemorrhage following a minor procedure or surgery? ☐Yes ☐No

Do you, or have you ever, suffered from recurrent nosebleeds? ☐Yes ☐No

List any current medical conditions: _____

_____

_____

List any other medical facts or information you feel should be known by our doctor before you undergo any type of procedure:

_____

_____

_____

_____

_____

_____

(use the backside of this form if additional space is required for this or other questions)

For Female Clients:

Number of pregnancies: _____ Did you breastfeed? ☐Yes ☐No

Date of last period: _____ Are your periods heavy? ☐Yes ☐No

Medical History Questions:

1. Have you had a heart attack or stroke within the last twelve (12) months? ☐Yes ☐No
2. Are you currently taking steroids or any other immunosuppressant medication? ☐Yes ☐No
3. Are you currently pregnant or breastfeeding? ☐Yes ☐No
4. Are you currently undergoing radiation or chemotherapy for cancer? ☐Yes ☐No
5. Do you have a history of skin disease or connective tissue disorder? ☐Yes ☐No
6. Do you have severe emphysema or other oxygen dependent condition? ☐Yes ☐No
7. Are you currently taking Coumadin, Plavix, Aspirin, Ibuprofen, or any other blood thinners on doctor's orders? ☐Yes ☐No
8. History of a bleeding disorder or excessive bleeding? ☐Yes ☐No
9. Do you have a history of keloids or abnormal scarring? ☐Yes ☐No
10. Are you allergic to latex? ☐Yes ☐No
11. Do you have a progressive neurologic illness (current paralysis, multiple sclerosis, Parkinson's)? ☐Yes ☐No
12. Do you have a history of hyper- or hypo-pigmentation after skin injury? ☐Yes ☐No
13. Do you have a pacemaker? ☐Yes ☐No
14. Angioplasty with a stent placement? ☐Yes ☐No
15. Heart catheterization / stress test? If yes, date: _____ Results: ☐Normal ☐Abnormal ☐Yes ☐No
16. High blood pressure? ☐Yes ☐No
17. Mitral valve prolapse? ☐Yes ☐No
18. Limited spine mobility? ☐Yes ☐No
19. Restless leg syndrome? ☐Yes ☐No
20. History of abdominal surgery or C-section? ☐Yes ☐No
21. Poor wound healing? ☐Yes ☐No
22. Psychiatric disease that required hospitalization? ☐Yes ☐No
23. Reaction to Lidocaine? ☐Yes ☐No
24. Angina or chest pain with exercise? ☐Yes ☐No
25. Do you bruise easily? ☐Yes ☐No
26. Coronary artery disease or history of heart attacks? ☐Yes ☐No
27. Diabetes that cannot be controlled with diet? ☐Yes ☐No
28. Hepatitis B or C? ☐Yes ☐No
29. Tuberculosis? ☐Yes ☐No
30. Sickle cell anemia or trait? ☐Yes ☐No
31. History of aortic aneurysm? ☐Yes ☐No
32. History of hernia (ventral, umbilical or inguinal)? ☐Yes ☐No
33. History of stroke? ☐Yes ☐No
34. HIV/AIDS? ☐Yes ☐No
35. Irregular heart beat (arrhythmia)? ☐Yes ☐No
36. History of kidney insufficiency or failure? ☐Yes ☐No
37. Liver insufficiency or Cirrhosis? ☐Yes ☐No
38. Phlebitis, blood clot or deep vein thrombosis (DVT)? ☐Yes ☐No

Acne History Questions:

39. Are you currently taking acne medication? If yes, which? _____ ☐Yes ☐No
40. Have you ever been on Retin-A for acne? ☐Yes ☐No
41. Have you ever taken Accutane for acne? If yes, start date: _____ End date: _____ ☐Yes ☐No
42. Have you ever been on antibiotics for acne? If yes, when did you stop? ☐Yes ☐No
43. Rate your current skin condition. Is it the same, better, or worse than usual? ☐Better ☐Same ☐Worse
44. What current medications are you taking for acne? _____
45. For women with acne: Have you noticed a change connected to your menstrual cycle? ☐Yes ☐No

I acknowledge that I have disclosed my complete medical history and the above is complete and accurate to my knowledge of my medical and psychological status. I am at least 18 years of age or, if not, I am accompanied by a legal guardian. I hereby consent to and authorize that Boston Cosmetic Surgery Center staff take a medical history in order to evaluate, plan, and help educate me on the possibilities of procedures I can be offered. I understand that photos are helpful and I authorize the taking of photos, which will be used solely for documentation and be kept confidential. I agree that any critical omission or misrepresentation may lead to change in pricing or cancellation.

Please review the above information for accuracy, which you hereby verify by signing below.

Signature: _____ Date: _____ Relationship to client: ☐Self ☐Spouse ☐Parent ☐Guardian

ACKNOWLEDGEMENTS

1. Client covenants and agrees that he/she shall not, in his/her own name, pseudonymously, or anonymously, hereafter engage in conduct that involves the making or publishing of written or oral statements or remarks (including, without limitation, the repetition or distribution of derogatory rumors, allegations, negative reports or comments) orally, on paper, electronically, or through any other medium, which are disparaging, deleterious or damaging to the integrity, reputation or good will of Dr. Ishoo, Dr. Davison and or Boston Cosmetic Specialists.

Client Signature: _____ Date: _____

2. I understand that I will require an adult escort to accompany me home following the operation as a matter of client safety because I will have received medications during the procedure. I also understand that I am strictly prohibited from operating a motor vehicle immediately after the operation and for as long as I am taking narcotics or sedatives, which can impair my judgment and motor skills putting myself and others at risk for injury. I understand that if I do not have an escort my procedure will be rescheduled at my expense to a date where one can be made available.

Client Signature: _____ Date: _____

3. We value our clients' privacy and in order to protect your privacy, it is the policy of this office to prohibit the use of sound, video and other electronic recording devices, including cell phone cameras. The use of such devices is a violation of the right to privacy of both our clients and employees. By signing below, client agrees that such conduct is an invasion of the privacy of others and will refrain from using recording devices on Boston Cosmetic Specialists premises.

Client Signature: _____ Date: _____

4. For female clients: I acknowledge that I am NOT pregnant NOR breastfeeding at this time. I understand that if I become pregnant or suspect that I am pregnant I must notify the doctor and his staff prior to any procedure involving medications.

Client Signature: _____ Date: _____

BOSTON COSMETIC SPECIALISTS POLICIES

Appointment Policy:

- We require a credit card number to reserve your appointment. Please give us at least forty-eight (48) hours notice for appointment cancellations or to reschedule an appointment. If you cancel or reschedule your appointment with less than forty-eight (48) hours notice, or fail to come to your appointment, a $50 cancellation charge will be applied to your credit card.
- Our quotes and deposits are valid for fourteen (14) days.

Payment Policy:

- We require payment in full at least two weeks prior to the day of procedure in order for the procedure date to be confirmed. We accept cash, Visa, and MasterCard, and we offer financing options through specialized financing companies listed on our website.. We do not accept personal checks.

Refund Policy:

- Boston Cosmetic Specialists will not issue refunds for services purchased or rendered. We may, at our sole discretion, issue a full or partial credit for use at our facility towards other services. This credit may not be transferable.
- We are committed to setting up realistic expectations. All clients must recognize that results vary based on a variety of factors, so there is no guarantee of specific results.
- If returned unopened or unused, our products may be exchangeable for other products, facility credit, or monetary refund. Exchanges, credit, and refunds are at the sole discretion of Boston Cosmetic Specialists.

Procedure Change or Cancellation:

- By scheduling and paying a one-third (1/3) and/or full payment for your procedure, You are confirmed for your procedure on the date you have selected. If you need to change or cancel your procedure within two weeks prior to your procedure, a nonrefundable fee of twenty percent (20%) of the surgical fee or $500 (whichever is greater) will be ducted from your account with us.

Accepted and Agreed To:

Client Signature: _____ Date: _____